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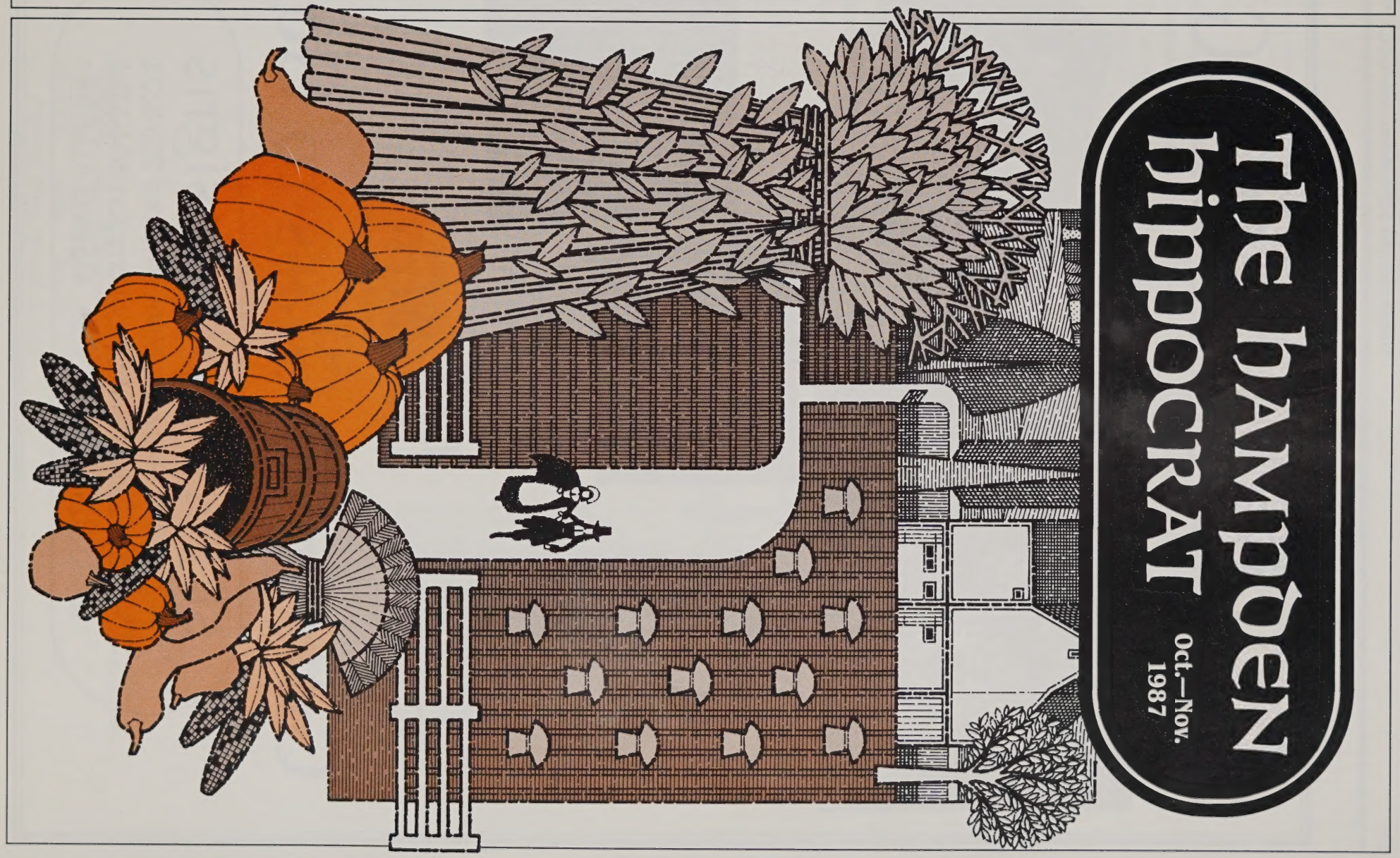

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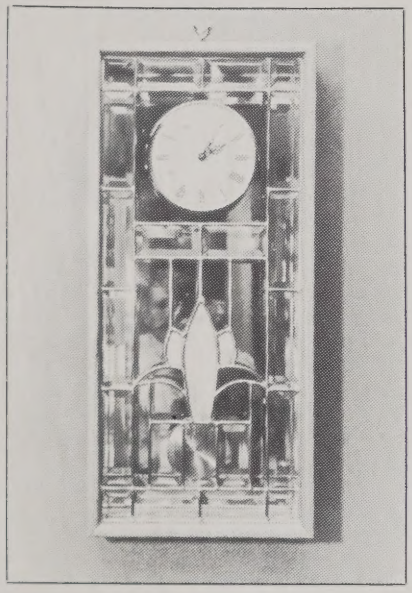

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THE HAMPDEN HIPPOCRAT

VOLUME XXXXIII NO. 6
OCTOBER—NOVEMBER 1987

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Telephone: 736-0661

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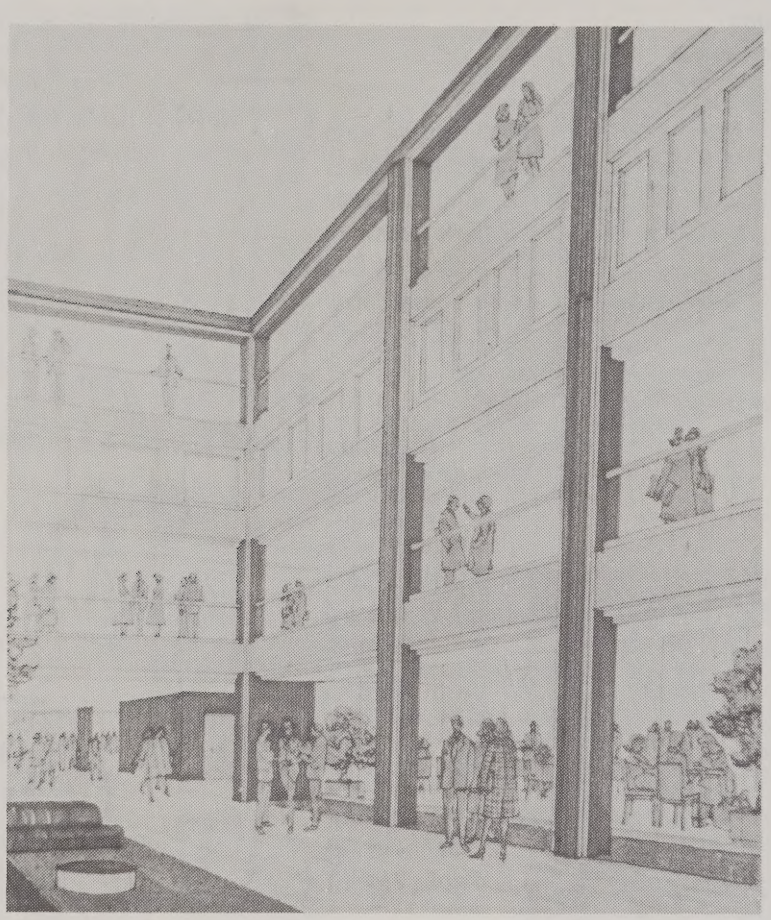

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THE HAMPDEN HIPPOCRAT

CONTENTS

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VOLUME XXXXIII NO. 6

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IN THIS ISSUE

HDMS President's Message	6
Report on September District Meeting	8
Stop The Blues	11
Would We Do It Again?	13
"It's Just A Job, Isn't It?"	15
A Notice From The American Liver Foundation	16
Welcome New Members	17
A Letter From HealthPro, Inc.	19
Springfield Academy of Medicine Library Notes	20
Thank You	21
In Memoriam	21

THE HAMPDEN HIPPOCRAT is published bi monthly.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, MA 01109: Telephone: 736-0661.
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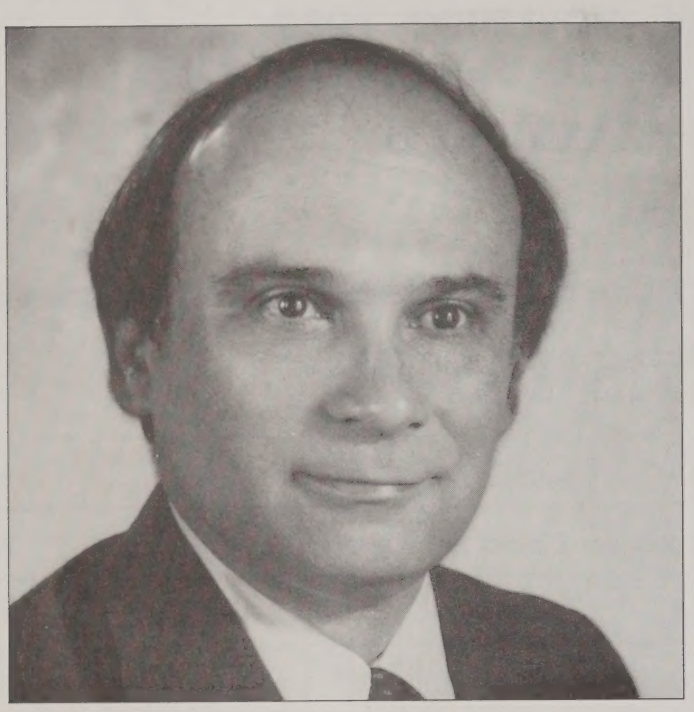
HDMS President's Message



Gregory A. Slachta, M.D., President

I have been spending a great deal of time between Boston, Washington and Chicago these days. I really do know what they mean by frequent flyer. Allow me to give you some of my thoughts on current events as I enter the last six months of my presidency.

Malpractice (professional liability) insurance: The JUA is requesting another 140 million dollars to pay for reserves and real dollar losses from 1975 to 1983. This would cause an average rise of approximately ten thousand per physician. If rated it would increase class 7's by an additional 30 thousand dollars. We would have to print money to pay for that. The Governor's office declared the crises over because there will be no rate increase this year. That is a small consolation in face of last years raise in rates. The Mass Medical Society funded a study to review the possibility of a state-wide voter initiative (referendum) for further tort reform. Though the study indicated large support for joint and several liability (deep-pocket) reform, restriction of contingency fees to 10%, and majority support for a $250,000 cap on non-economic damages, the leadership and legislative committee chose not to go forward because of: cost (3 million dollars); affecting relationships with the legislature; fear of losing. Hampden, significantly affected, voted for referendum as did Worcester. We will not be able to obtain referendum relief until 1990.

Blue Shield: We have not moved affectively closer to legislation than we had in May. Efforts to work jointly with Blue Shield toward supporting legislation to end the lock-out have stalled, Blue Shield can support non-participating legislation and balance billing but cannot support a floor on the amount to be payed to non-participating physicians. They would desire the purchaser decide that percentage. I personally can support this because I believe the market should dictate the percentage. I believe it would be difficult in the Springfield market to sell a plan without significant reimbursement to non-participating physicians. With a small number of specialists it is very difficult to market any plan that selectively contracts. Only those plans that have wide-based physician participation will be successful. The real losers, of course, are the patients, particularly those with medex and pre-existing illness, who cannot switch coverages. It's unlikely for non-participating legislation to occur without a joint legislative lobbying effort of Blue Sheild and the medical society in the face of the Governor's presidental aspirations and the wooing of labor.

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Additionally, look for Blue Shield to be marketing a PPO product in the future when legislation permits. I predict it will be their main product. Again, the key to that success will be selective contracting. Look, however, for this product to reimburse non-participating physicians about 80% and being able to balance bill patients. It will be necessary to protect balance billing of charges and not of Blue Shield reimbursement. Also, it is essential to secure the right of physicians already or still participating by contract with Blue Shield in other Blue Shield plans to be able to be non-participating in their PPO and balance bill charges.

Governor's Universal Health Bill: This has to be the Governor's source of greatest discomfort. He was ill-advised that it was a very doable situation and it has been sent back to the Ways and Means Committee for intensive care. Needless to say, It was meant to give the campaign a real boost in the arm. It was a devastating missassessment of the legislature. It was dangerous by its preamble alone. It established the principle that employers are responsible for their employee's health. Not just on the job but off as well. What was once a benefit of collective bargaining was now an employee's right and an employer's responsibility. That's not far from it's a patient's right and the state's responsibility. The difference is not in philosophy but rather as to who is to pay the bill. I believe the enactment of that bill would have all but been the death-knell to many small business's in the commonwealth. I also question the proposed health czar in light of this administration's health track record. Hopefully it will not resurrect itself without more careful thought.

Washington D.C.: If you think we have problems in the state just wait until you hear about Washington. Our friend's at HCFA have determined that we will be the scape-goat for the budget deficit. You have all read that the reason Medicare Part B costs are going up is because of physician largess. As Dr. William Roper, Head of HCFA (Internist, Alabama) put it to Senate Finance, every dollar removed from the charge to subscribers the government will go 400 million further in debt; that doctors are the prime cause of this inflation of costs. What is interesting is that physician reimbursements have been frozen for twenty-eight months; that the Medical Economic Indicator raises have been delayed and reduced; that the federal government chose not to raise rates last year because of an election and is playing catch up. Integrity is not Bill Roper's middle name. If Medicare gets the kind of reductions it is looking for next year look for a significant problem to occur in Western Massachusett because of our mandatory assignment law.

Medicare, by the way, intends to develop preferred provider organizations with the carrot being diversion of volume to physicians who will accept a discounted rate below the present Medicare reimbursement.

In Congress, Rep. Brian Donnelly (D-11th Cong Dist., Boston) is forcefully attempting to mandate assignment and, along with his chairman and cohort on the Health Sub-committee of House Ways and Means Rep. Pete Stark (D-Cal), blame all the deficiencies of the Medicare system on the greed of physicians. Sooner or later, the elderly will wake up to their unfounded bias and realize they were duped. In the meantime, it will be necessary for us as physicians to continue to educate them in our offices and assume, and rightfully so, the role of advocate.

I'm sorry I didn't see more of you at the last district meeting. Our speakers were excellent. Rep. Lee Daniels, Minority Leader of the House of the Illionis State Legislature, Illinois Campaign Director for Bob Dole for President, and President-elect of the National Association of State Legislators, spoke eloquently on physician participation in politics and his role in the passage of the Illionis tort reform ligislation last year.

Dr. Herbert Sohn, a urologist from Chicago spoke of his Congressional run last year, albeit unsuccessful, a lesson in civics for all of us.

It's time for all of us to get aboard if we desire control of our own destiny. Your suggestions for a viable, functioning district should be made to Dr. Rocco Verrilli through Carol Nystrom. Our Ad Hoc Blue Ribbon Long Range Plan Committee will be making recommendations later this year. Please give input now. Participate now. Don't complain later.

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Report on September District Meeting

The September meeting of HDMS was held on September 22, 1987, at Chez Josef in Agawam. It was attended by 120 physicians, spouses, and invited guests.

The business meeting began with a short film on the United Way and remarks by Dr. Kenneth McEwen to encourage physicians to participate. Mr. George Roy, Director of Health Services Research for MMS, then discussed the current status of Governor Dukasis' Mass Health Partnership Bill. Our MMS president, James J. Siragusa, M.D., subsequently joined in the discussions. He stated the MMS was conceptually in favor of the bill and approved of the overall concept; however, they were fearful of beaurocratic management by the state and over-restriction of hospital reimbursement. Mr. Roy stated that we were to expect very complicated and heated discussions and much publicity over the next several weeks. He turned out to be correct.

Dr. Rocco Verrilli reported on the beginning of a long range planning committee. Dr. Philip Stoddard reported on the ongoing financial reorganization of MMS and NEJM. It was finally reported that the next business meeting would be held on January 28, 1988, and that James Davis, M.D., President-elect of the AMA, would be the guest speaker.

Mr. George Roy of MMS informs membership.

Representative Lee A. Daniels of Illinois received plaque.

At the dinner portion of the meeting we were joined by invited legislators. Senator Martin T. Reilly, and representatives, Iris K. Holland and Anthony M. Scibelli.

Following dinner Dr. Slachta made a brief plea for physicians to participate in the political process, and introduced the first of two guest speakers from Illinois, Representative Lee A. Daniels, House Minority Leader of the Illinois General Assembly.

Representative Daniels discussed Illinois' approach to medical malpractice reform. He stated that they felt it was important to get the message out to the general public that medical malpractice is not an isolated phenomenon, but is causing difficulties in many professions. Many legal firms have had to go off shore to obtain coverage. He went on to say that malpractice needs to be addressed on a national level, but up until now Congress will not move on it, so states have to.

The tort Reform Bill passed in Illinois last year is said to be working well. It covered such items as structured verdicts, itemized verdicts, collateral source rules, non-involvement certification to allow quick dismissal of cases, counter suit actions, contingency fee limitations, limitations on punative damages, and expert witness provision and a provision relating to medical records.

With this legislation behind them Illinois is now looking for ways of improving physicians' actions and doctor/patient relations. He quoted Dr. Todd of the AMA as saying "Happy patients don't sue their doctors." And he encouraged the physicians to take a few extra minutes to keep their patients happy.

Representative Daniels then went on to encourage us to become more involved in the political process, encouraging friends to run for office and to contribute to the campaigns of good candidates with money and time. In addition, however, we must not assume that the persons running for office understand the intricacies of medicine or the laws that relate to it. Senators and representatives need to be educated on these and many other complex fields that they must deal with in order to keep introducing bills and getting them through committees.

Representative Daniels closed by saying that we must be aware that it is a war out there between the medcical profession and the trial lawyers; they are advocates and by their nature are argumentative, informed, articulate and driven. They never stop advocating their cause. You will see them talking at dinners, social gather-

continued

ings, and among their friends. The pressure they bring to bear on legislators cannot be under-estimated. Those legislators that take a stand on our side must be recognized for their courage.

Herbert Sohm, M.D. followed Representative Daniels with an interesting discussion of his attempt to run for Congress. Dr. Sohm is a urologist in the Chicago area, as well as a graduate of Hohn Marshall's Law School in Chicago. Dr. Sohm ran for Congress in 1984 and 1986, winning the primary, but losing the election on each occasion. After describing his early interest in politics, he related how he found himself running against an incumbent of 40 years. He described the organization of the campaign and the necessity to find good committee workers, the importance of establishing name recognition and of finding your opponents' strengths and weaknesses. Incumbency is a major advantage. Dr. Sohm said that money is the most difficult problem, particularly for an unknown candidate. He had found it necessary to seed his campaign fund with his own money and to have friends and relatives and professional associates develop a network to raise funds. Dr. Sohm closed by reminding us that physicians are caring people and should make good legislators and should consider getting invloved.

Dr. Slachta presented Representative Daniels and Dr. Sohm with antique plaques as gifts from the society and thanked them for their excellent presentations. ■

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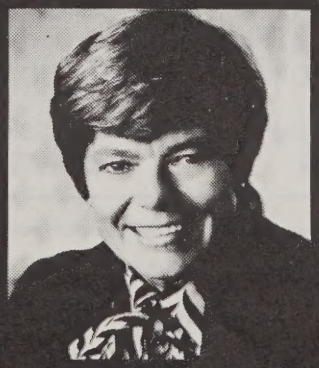

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Stop The Blues

In April of 1987, the Massachusetts Association of Community Health Agencies (MACHA), along with 12 Massachusetts based Visiting Nurse Associations, filed suit in the first District Court in Boston against Blue Cross/Blue Shield of Massachusetts, the Department of Health and Human Services, and the Health Care Financing Administration, charging that our rights have been violated under the Medicare statute, the Administrative Procedure Act, and the United States Constitution, through the mechanism of technical denials of visits made by us to Medicare patients. These denials determined by Blue Cross of Massachusetts have been retroactively applied to periods as far back as 1984, and have cost Massachusetts agencies thousands of dollars, both in administrative time and in the alleged amount Blue Cross claims we owe them for the denied visits. For the Holyoke Visiting Nurse Association (Holyoke VNA) alone, Blue Cross is seeking a payback of over $39,000.

Technical denials, according to the fiscal intermediary (Blue Cross of Massachusetts) and ultimately the Health Care Financing Administration, are not appealable. These claims are defined as visits denied because of contractual issues. For example, a level of care is mailed to you for your medical orders and signature on a patient you may have referred for home care. If this level of care (form 485) was filled out incorrectly, reimbursement for care provided by the VNA to the patient has been denied retroactively and Blue Cross wants the money back that has been paid to the VNA. (Blue Cross pays the home health agency as soon as they receive the bill. Blue Cross then reviews the claim and denies the visits retroactively and therefore wants the money back that they paid out prior to review. This practice is contrary to how you, the doctor, is paid by Blue Cross.) This denial is not appealable (i.e. there is no opportunity to correct the form and resubmit it for processing). Other examples of technical denials include:

1. If the form was submitted to Blue Cross when the physician signed the orders after the care was actually given in the home (i.e. we functioned on a pre-existing verbal order or a hospital transfer order until you had an opportunity to sign the level of care and send it back to us).
2. If the duration of the care provided by the VNA was not included in the medical order, in spite of the fact that the form itself certifies your orders for a 60 day period.
3. If there was no skill listed on the order (e.g. if you ordered a physical therapist for a patient with a total hip replacement but neglected to put "for gait training and strengthening excercises", or if the home health aide was ordered but neglected to add "for personal care and meal preparation").

The above examples constitute an incomplete form 485 or "lack of physician's orders" as defined by the fiscal intermediary, Blue Cross of Massachusetts, and we have been denied payment of these visits as a technical denial with no appeal rights. Although there are other examples of technical denials, such as the patient not being homebound (i.e. basically this has been interpreted to mean bedbound), or if the care was not rendered in the place of resident, or if the care was not intermittent. However, the majority of technical denials experienced by the VNA's have been due to an incorrect detail of the form itself, which was submitted to Blue Cross for payment. We feel that this is terribly unfair and unjust, and certainly an inappropriate way to reduce health care costs (i.e. putting us out of business).

The Blues and the government have even taken this atrocity one step further. The major difference now, however, is that the fiscal intermediary has been switched

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Stop The Blues

continued

to Blue Cross/Blue Shield of Maine and they are now making denials based on care that they claim was not medically reasonable or necessary. This is what happens; you order specific care (nursing, physical therapy, home health aide, etc.) for your patient upon hospital discharge. The VNA provides the care and the medical reviewers in Maine deny the care, second guessing the medical judgement you have made for your patient and indicating that the care that you ordered (and we provided) was not medically necessary. We, the VNA's, are denied payment for the services and we cannot (due to Federal laws) bill the patient for the denied services. When Medicare denies services for medical necessity, the beneficiary does not have an appeal right, but generally speaking, the 85 year old patient does not have the strength nor the ability to process an appeal on their own behalf... and we believe that the government not only knows this, but is counting on it as a covert cost reduction mechanism.

This process of arbitrary and capricious denials is being challenged by the VNA's through the Massachusetts Association of Community Health Agencies (MACHA) and the National Association for Home Care (NAHC), and we are now preparing to press suit against Maine Blue Cross, the Department of Health and Human Services and the Health Care Financing Administration regarding medical necessity denials. (There has already been one suit filed nationally on this issue sponsored by Congressman Harley Staggers).

What are we asking? That you refer your patients elsewhere? No. The VNA's have done a good job in caring for them for all of these years, and by your support, we think you agree. What we do ask is that you, first of all, become fully aware of the Medicare denial situation as it jeopardizes us and your patients. We do not feel that Medicare has the right to usurp your role as the patient's private physician in second guessing what is medically necessary for the proper care of that patient. And we are confident that you agree. It is also important to know that the government is harrassing us too... another member of your health care team known as the certified home health agency. We, too, are being raked over the coals by requests for voluminous documentation, and we are being financially threatened by Medicare denials on patients who in many cases are too feeble, weak, and perhaps indignant to fight the system. So we ask that you help us in helping them to fight the battle. The first step is knowledge and awareness. We have begun that process. The second may be to speak out on our behalf whenever you have the opportunity. You may be asked to write a letter to your Congressman, or even a letter to the medical reviewer of the fiscal intermediary responsible for denying the care, to further state your opinion as a competent physician (i.e. to support why the care that you ordered was reasonable and necessary). We know that you have many, many other battles with insurances, the government, and bureaucracy, and we, too, are empathetic and supportive of those other issues that you must face as a practicing physician in Massachusetts. However, unless we pull together as a team in voicing our concerns, I fear we will be forced to succumb to the Blues for the ultimate answer as to what is medically reasonable and necessary for our Medicare patients at home. ■

Phyllis A. Capers, President
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The following essays by Merritt Low, M.D., and Nathaniel Clark, were submitted to the "Pride in Medicine" contest. The Editorial Board feel that they are worthy of your consideration.

Would We Do It Again?

The loaded question often asked a doctor nowadays is, "Would you really do it (i.e., go into Medicine) all over again if you had the chance?" The answer requires an honest analysis of the basis for the original quest, and an even deeper probe into the fundamental character of the obvious changes in Medicine and our milieu itself in the past half century. How are these changes affecting patient-physician relationships? Is there irreparable damage? I think not. Can we adjust to the new ambience? I think so. There have been relevant changes in ourselves too—more time off, more group coverage, more consultation and division of responsibility. An often authoritarian stance has been mollified into an authoritative one. Old-fashioned doctors are no longer around, but neither are old-fashioned patients. Twin explosions of knowledge and technology have given more visibility and importance to "science" over "art," as if the two were truly dichotomous, as if science should be pre-emptive, as if technocracy should be allowed to run away with the show. A new triad of partnerships (physician, patient and family, and the "third party," payor) has been catapulted into the picture.

It was indeed exciting, when we began, to get an inkling of things to come as we bathed in the benefits of the new break-throughs in pernicious anemia and diabetes-impacts just being appreciated when we were students, tributes to humanitarianism and rewards for the scientific method. Advanced brain operations, lobectomies, burgeoning cardiac procedures heralded the birth of the "new" surgery. Little did we know what more was to come! We focused (to everyone's benefit!) on accurate diagnosis, as treatment of many conditions was at best meager. This verged on the prosaic at times. However, we relished the humanity in our relationships. Our morality was one of commitment to the individual-and was rational and satisfying, though in a way it may have been a refuge, allowing us cavalierly to eschew general societal involvement as we escaped the hurly-burly of more public careers such as business or "unsavory" politics. We were proud of our knowledge, our individualism, the "new" medicine (isn't it ever thus!), and the dependence we engendered (often easily enough) in our patients. We did not want to play God, but we enjoyed being on the pedestal with the priest and the rabbi. We were private entrepreneurs, eager to earn a good living without being money-grabbers. Our starting baseline needs were minimal. We were dedicated and well compensated in every way. We had time for house calls, although not enough for our own families. We were proud of ourselves and our elite profession, and proud of the esteem in which we basked and the accolades which came our way. If we were "fads" for awhile we tried to take this with humility and grace. Some of us had gone into research, some into teaching, some into patient service and care— and we all rejoiced as we became part of the therapeutic blossoming of the decades unfolding— the "sulfas", penicillins and other antibiotics; the new vaccines for diphtheria, poliomyelitis, measles and the others; the drops in mortality and morbidity rates; the "plastics" and new intravenous techniques; the arrival of modern anesthesia and the era of organ-transplants; the newly defined holism and the meld of science and humanism; the birth of scientific genetics.

The exciting, demanding, fulfilling times have now turned into parlous ones. Why? Our values have become questioned. Our societal, democratic pluralism has been fraught with conflict. Our ethical systems have become uncomfortably, uncertainly multi-faceted, unhinged by uninhibited doubts frankly espressed and broadcast without restraint. Others have invaded areas we used to feel were sacrosanct, were "ours". Better medicine has meant higher costs, and higher costs have begotten controls; yet, paradoxically, both physicians and patients have distanced themselves from finances till come the painful reminders. We have all become ill-conceived, unloved children of a bureaucratic-computer marriage. One could scarcely conjure up a pair of more amoral parents! Our mistakes now require airing, even though they are proportionately and comparatively fewer than in many walks of life; but being accountable is indeed as it should be, if completed and judged with appropriate awareness and sensitivity. We still have to sail out beyond the constricting harbors of perfectionism. As we share decision-making, so must we ask for a sharing of responsibility, so we are not solely involved in the final result.

We are in ferment, in a way symptoms of an anxious

continued

Would We Do It Again?

continued

world in flux. Our patients still like us as individuals. We carry good image-ratings. The basic fabric is there, but we have to strengthen the threads that connect our great profession with the goals and ideals of the past, while we adapt to the humanistic needs, realities and relationships of the future. Being "islands" in society is a luxury no longer tenable. We must join with others in the newly defined concept of "community", taking our individualism into a synergic whole. Here we have much to offer and our basic tenets are well known. Already we can be proud of our contributions in evaluation, accountability, on-going education of ourselves and others. We still lag some in participation but that is stirring. We have values not everyone clearly shows or sees in the market-place and we must cling to them. Our main message is that a person is an individual. An expert in public relations once told me that the core of "P.R." rests in the telling of the truth, not in the use of gimmicks.

We do not have to "run scared." There is an old motto, ESSE QUAM VIDERI (Rather Be Than Seem), which some in a sick part of society have twisted to VIDERI QUAM ESSE. The medical profession can be proud that we do not go for that—and here our precepts can be helpful to many others. The reasons we went into medicine-individualism, humanism, contribution, empathy, scientific curiosity, and self-satisfaction and fulfillment in a basic discipline within which to give thanks for life-are as appropriate as ever and more necessary to re-assert. Our immediate heritage and accomplishments give reasons to be proud. There have been more medical advances in the past fifty years than in all of previous human history. There is ample reason to be sanguine despite temporary frustrations. You've guessed it! My own answer to the initial question is a resounding "Yes"!■

Merrit Low, M.D.
Franklin District Medical Society

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"It's Just a Job, Isn't It?

It was a beautiful Spring day when, as a first year medical student, I went down to the shores of Lake Quinsigamond with a group of my classmates for a bit of afternoon relaxation. We found ourselves discussing what we saw as the demands of being a physician. As so often had happened in the past, particularly with this group of friends, the discussion turned to how one could juggle the demands of medicine with those of having a family. I made the statement that medicine was to be the center of my life. One of my classmates responded that having a family was very important to her and that being a doctor was "just a job, isn't it?" Over the last two years these words and the concept behind them have continued to be on my mind and distress me greatly.

The experience of entering medical school in the 1980's, to begin what seemed like an endless training process was not without its moments of pause. We began our orientation on day one with the Dean/Chancellor stating that we were entering medicine at a "difficult time". No longer could we expect, as those before us had, that upon completing our training we could be assured of (1) a supportative public who would come to us with trust and great appreciation for our efforts, (2) the opportunity to treat our patients based on our training, current theory, and our personal beliefs, without the intrusion of outside agencies and (3) a salary which society believed we deserved. Hearing this I remember feeling not distressed, but rather inspired. It "incited my competitive spirit" as a mentor of mine was prone to remark. I saw this as a personal challenge to work during my career in medicine to bring medicine back to its formerly revered status. Initially, I could not be specific as to how I would accomplish this but, then the discussion with my classmates occurred and it became more clear to me.

Webster's dictionary defines "job" as a piece of work... done by agreement for pay... anything one has to do... a thing done supposedly in the public interest but actually for private gain". On the other hand, "career" is defined as "a lifework, profession, occupation" and "occupation" as "the principal business of one's life". When practicing medicine becomes "just a job" rather than "career" or "occupation" we're in the midst of a crisis.

My overall concern is that this is a crucial time in medicine and if we are to be victorious in rebuilding our profession, we must reverse the present downward trend. My specific concern is that physicians currently in training see how medicine has changed and are making changes in the way they view medicine and their future in it. Some of these individual viewpoints do little to maintain the high standards for which the profession has been noted.

I hear more and more from classmates that they want to be doctors but also "to be people, too" as if the two were mutually exclusive rather than quite interrelated. These students are choosing one field of medicine rather than another based on such concerns, sometimes aspiring to be "9 to 5 doctors". In the past, the saying "to whom much is given, much will be expected" described the mindset of physicians; many now seem to be saying "if much less will be given, much less should be expected". Unfortunately, this becomes a self-fulfilling profecy which can only end in the further decline of the profession.

Although we can not deny that new challenges exist today in medicine, we must never come to see what we do as "a job". In the first week of medical school we were told that we had the opportunity to be with our patients and share with them some of the most crucial and intensely private personal experiences of life and death. As I have progressed from the classroom to my clinical experiences these truths became more evident. The opportunity to interview and examine an ill patient, assist in the diagnostic process, to sit with him or her and discuss their hopes and fears, to attempt to answer their difficult questions and in the best circumstance to assist them in the recovery of both their health and previous lifestyle is without equal.

Currently, I am in the midst of my clerkship in Family Medicine. In the last two weeks alone, I have had the opportunity to assist my preceptor in delivering a baby and witness the parents' joy and excitement, providing terminal care and support to a patient at home, and to discuss such issues as depression, divorce, alcoholism and job stress with individual patients. What these patients seem to appreciate most, or at least what they verbalize, is that their doctor is "there for them" when they need him. The enormous power of the reassuring touch, the supportive word and the doctor's recommendation is very evident in this setting.

A few months ago while visiting a friend who has always been very suportive of my desire to be a doctor, I found myself trying to explain what being a doctor meant to me. While I felt that a person could perform a vital service to society through variety of career paths, I viewed my career as a physician as a special calling, perhaps one without equal. I am grateful for the opportunity to become a physician. I remain convinced that if we do the very best we can for our patients, they will do their best for us. Being a physician will remain a very honorable endeavor in our society. ■

Nathaniel Clark

A Notice From The American Liver Foundation

1987 Sees Progress in Fighting Liver Diseases

"We've seen some very exciting progress in fighting liver diseases during the past year," said Thelma King Thiel, president of the American Liver Foundation, as the organization geared up for the observance of National Liver Awareness Month in October.

Three notable advances she cited were:

1. Release of genetically engineered vaccine against hepatitis B.
2. Researchers are coming close to isolating the non-A, non-B viruses transmitted through blood transfusions which would make possible more effective screening of blood.
3. A dramatic growth in liver transplants, from 602 in 1985 to 922 in 1986, with more than 1,500 expected in 1987.

"With the vaccines we now have available, we should be able to prevent the 300,000 new cases of hepatitis B that occur annually in the United States" said Thiel. "The American Liver Foundation is carrying out a campaign to have all pregnant women take a simple blood test to determine if they are carriers of the virus. If the test is positive, the vaccine can be given to the newborn child, protecting it against chronic hepatitis, which can lead to cirrhosis and liver cancer."

The Foundation is also trying to alert other high risk groups to the vaccine's availability. They include emergency workers, health care workers, military personnel, morticians, and certain ethnic groups.

Developing a more effective test for the puzzling non-A, non-B hepatitis viruses would prevent the 90,000 cases of hepatitis that result each year from blood transfusions, she noted.

"Liver transplantation, which was an experimental procedure only a few years ago, is now an accepted clinical treatment," Thiel observed. "For many children and adults with liver disease, it provides the only hope for survival. However, technical success brings some problems with it. There is a serious shortage of donated organs, especially for children. And transplantation is a very expensive operation, costing around $200,000, with thousands more for life-long medication to prevent rejection."

To help solve these problems, the American Liver Foundation carries out a year-round educational campaign on organ donation, sponsors research to find more effective treatments for liver disease, serves as trustees for transplant funds, and advocated legislation that will meet the needs of liver patients.

Free information on liver diseases, transplantation and organ donation may be obtained by writing the American Liver Foundation, Cedar Grove, New Jersey 07009. ■

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Welcome New Members

Howard G. Trietsch, M.D.
50 Maple Street
Springfield, MA 01103

BORN:	November 14, 1953
PREMED:	Rutgers College, New Jersey 1971-75
MEDICAL:	University of Trieste, Italy 1976-79 Tufts University School of Medicine 1980-83
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center 1984-87
SPECIALTY:	OB/GYN

Ethel Weinberg, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN:	June 1, 1936
PREMED:	University of Delaware 1953-56
MEDICAL:	Hahnemann Medical College 1957-61
INTERNSHIP:	Hahnemann Hospital, Pennsylvania 1961-62
RESIDENCY:	Jefferson Medical College Hospital 1973-76
SPECIALTY:	Administration (Presently Senior Vice-President for Academic Affairs BMC)

Saul A. Weinberg, M.D.
140 High Street
Springfield, MA 01199

BORN:	August 13, 1925
PREMED:	Yale University 1943-44 1946-48
MEDICAL:	University of Pennsylvania 1952-56
INTERNSHIP:	Philadelphia General 1956-57
RESIDENCY:	Philadelphia General 1957-59 Albert Einstein, Philadelphia 1959-60
SPECIALTY:	Psychiatry

Alan C. Weintraub, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN:	October 16, 1959
PREMED:	University of Michigan, College of Literature, Science & Arts 1977-80
MEDICAL:	University of Michigan Medical School 1979-83
INTERNSHIP:	Tufts New England Medical Center 1983-84
RESIDENCY:	Yale New Haven Hospital 1984-86
FELLOWSHIP:	Yale New Haven Hospital 1986-87
SPECIALTY:	Anesthesiology

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John P. Frangie, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN: June 23, 1961
PREMED: University of Kansas, Lawrence, KS 1979-83
MEDICAL: University of Kansas, Kansas City, KS 1983-85
University of Kansas Wichita, KS 1985-87
INTERNSHIP: Baystate Medical Center 1987-present
SPECIALTY: Opthamology
INTERN:

Eric T. Shebar, M.D.
Mercy Hospital, Department of Emergency Medicine
271 Carew Street
Springfield, MA 01104

BORN: April 29, 1956
PREMED: Franklin & Marshall, PA 1973-75
Johns Hopkins, Maryland 1975-77
MEDICAL: John Hopkins, Maryland 1975-1980
INTERNSHIP: Hospital of the University of PA 1980-1981
RESIDENCY: New England Deaconess, Boston, MA 1981-83
SPECIALTY: Emergency Medicine

James R. Schumacher, M.D.
444 Montgomery Street
Chicopee, MA 01020

BORN: September 23, 1952
PREMED: Rensselaer Polytechnic Institute 1970-71
Tufts University 1971-74
MEDICAL: Albert Einstein College of Medicine 1974-77
INTERNSHIP: Montefiore Hospital, Bronx, NY 1977-78
RESIDENCY: Montefiore Hospital, Bronx, NY 1978-80
FELLOWSHIP: Downstate Medical Center, Brooklyn, NY 1980-82
SPECIALTY: Rheumatology/Internal Medicine

Robin Gottlieb, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN: September 18, 1953
PREMED: Sarah Lawrence College NY 1971-75
MEDICAL: SUNY at Stonybrook 1983-87
INTERNSHIP: Baystate Medical Center present
SPECIALTY: Physical Medicine & Rehabilitation
INTERN:

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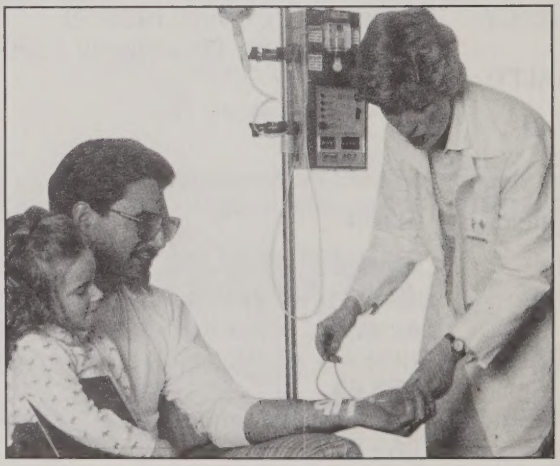

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A Letter From HealthPro, Inc.

Gregory A. Slachta, President
Hampden Medical Society
222 Carew Street
Springfield, MA 01104

Dear Dr. Slachta:

HealthPro, Inc., a physician peer review organization, is seeking physicians in various specialties to serve in an advisory capacity to HealthPro's review Committee.

HealthPro is incorporated in the Commonwealth of Massachusetts as a private, not-for-profit corporation. Governed by a physician member Board of Trustees, the organization is managed by an Executive Director who reports directly to the Board.

Organized in 1974 as a physician corporation dedicated to the principle of peer review, HealthPro was the federally-designated PSRO in central Massachusetts from 1975-1984. Since its inception, the organization has effectively administered a variety of review programs which have had the dual obligation of assessing the quality and the appropriateness of health care services. HealthPro currently operates: a private long term care review program; pre-admission, presurgical and concurrent review programs for businesses and private insurance companies; retrospective review, claims audit and management of information systems for industry; a model physician education and training program, funded by the National Fund for Medical Education; and a comprehensive cost containment program for the Department of Public Welfare, Commonwealth of Massachusetts.

HealthPro's mission has been to assure that the provision of health services meet professionally recognized standards of care, are rendered in the most appropriate setting and are medically necessary. We have the commitment and participation of a core group of physicinas who routinely convene to conduct peer review in an environment conducive to objective planning and analysis.

The advisory members would be enlisted to provide the expertise necessary to: 1) develop criteria, 2) perform case review, and 3) participate in special projects and/or studies.

HealthPro's physician advisors are reimbursed at a rate of $50 per hour.

If any of your members would be interested in participating with HealthPro as a physician advisor, please contact Beverly Pagano, R.N., Review Manager, at our office. ■

Sincerely,
Alan Krumholz, M.D.
Chairman, Review Committee

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Springfield Academy of Medicine Library Notes

The Library has witnessed many changes over the past year that we would like to review with the District Membership.

First, personnel changes:

Mrs. Margaret Stoler has left the Library to pursue her historical research. Peg served as Library Director for 5 years and ably managed the Library during extremely trying times. She will be greatly missed by all who worked with her. We wish her well in her new endeavors.

Mrs. Linda Rodger has replaced Peg as our Library Director. Linda has a Master's degree in Library Science and has had considerable library experience. We consider ourselves fortunate to have her on board.

Mrs. Sandra Burkin has also left the Library to pursue other personal activities. Sandy served with Mrs. Stoler as assistant librarian and watched over our financial and CME activities. We thank her for all her great work.

Mrs. Joanne Janovsky has taken over as assistant librarian. She comes to us with previous library experience, having worked at the Storrs Library in Longmeadow.

Secondly, there have been significant additions to the electronic facilities at the Library. With the help of a generous grant from the Massachusetts Medical Society Education Committee, we have acquired a facsimile machine that enables us to receive and transmit documents on a rush basis. We have also recently purchased our own microcomputer with telecommunications capabilities. With these additions, the Library offers its members "state of the art" on-line MEDLINE and other database searching capabilities and rapid facsimile transmissions. Our telephone and photocopying services have also been upgraded.

We urge all Hampden District Medical Society members to take advantage of *their* Library facilities. We can serve all of your library needs: medical book purchases at discount, literature searches, and reprint retrieval. Call us at 734-5445. ■

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October 20, 1987

TO: James G. Fitzpatrick, M.D., Chairman
Medico-Religious Committee

FROM: Gregrory A. Slachta; M.D., President

The Executive Committee at their October 19th meeting, asked me to extend our congratulations and heartfelt thanks to yourself and all the members of the Medico-Religious Committee for their dedication and hard work which resulted in the smashing success that was the Third Annual Medical Ethics Forum held on September 30th at Mercy Hospital.

We realize the work involved, but you and your committee made it look easy. Thank You!! ■

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IN MEMORIAM

The Editorial Board of the Hampden Hippocrat regrets to announce the demise of Massachusetts Medicine-unfortunately the November/December issue will be the last. We believe that this excellent, award winning magazine has been extremely well received by members of the Hampden District Medical Society and it is a great shame that the Massachusetts Medical Society has seen fit to discontinue assisting this growing venture to mature and become financially independent. Our thanks to Dr. John Ayres and his staff for every enjoyable and informative issue. If you feel as sad about this decision as we do, please address your comments in writing to Dr. Gus Siragusa at the Massachusetts Medical Society.

Nicholas P. Coe, M.D.
David W. Page, M.D.
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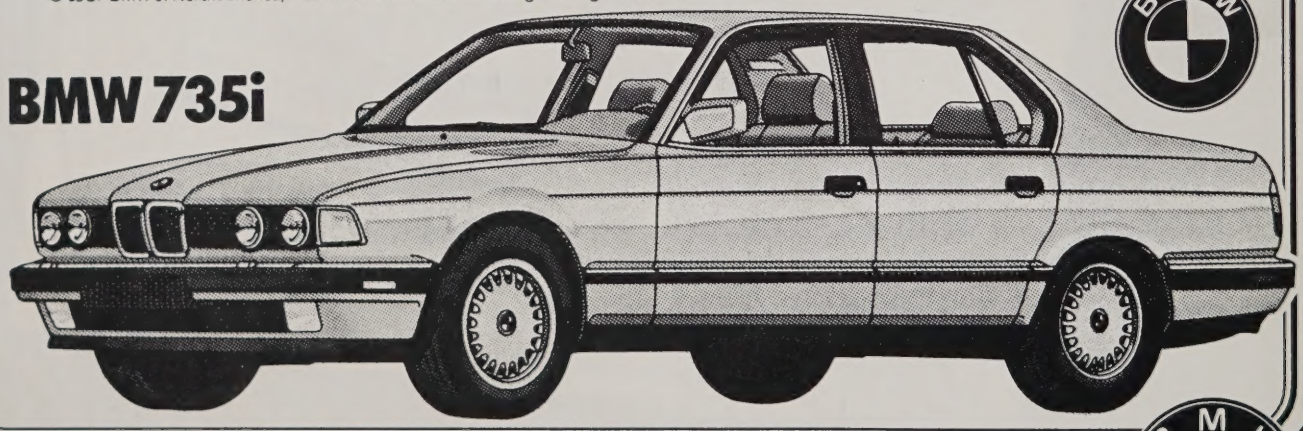

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